LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

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FISCAL IMPACT STATEMENT

LS 6873 **NOTE PREPARED:** Apr 14, 2003
BILL NUMBER: HB 1630 **BILL AMENDED:** Apr 10, 2003

SUBJECT: HIV Testing of Pregnant Women.

FIRST AUTHOR: Rep. Welch **BILL STATUS:** As Passed - Senate
FIRST SPONSOR: Sen. Miller

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: (Amended) This bill requires that a pregnant woman be tested for HIV during pregnancy or at the time of delivery unless she refuses. The bill requires that a pregnant woman's refusal to consent to the test be documented in the woman's medical records. It requires a pregnant woman who refuses to consent to the test to acknowledge that she: (1) received the required counseling and information; and (2) refuses to consent to the test. The bill also specifies certain information that must be provided to a pregnant woman. It requires that information regarding the HIV testing status of a pregnant woman be included on the confidential part of the birth or stillbirth certificate. It also makes the results of the tests confidential.

The bill also requires the State Department of Health to distribute written materials explaining treatment options for individuals who have a positive HIV test. It further repeals a provision concerning voluntary HIV testing for pregnant women and a provision containing an obsolete definition.

Effective Date: Upon passage; July 1, 2003.

Explanation of State Expenditures: (Revised) *Impact on of Required Testing on the Medicaid Program and State Employee Health Insurance:* The fiscal impact to the state is estimated to be the following: (1) The annual impact for those women and children in the Medicaid Primary Care Case Management (PCCM) program and fee-for-service claims is estimated to be $116,900. (2) In addition, while there is no short-term impact to the state for individuals in the Medicaid Risk-Based Managed Care (RBMC) program, increased costs of about $30,200 would likely be factored into higher capitation rates in the future. (3) There would also be additional annual costs to the health plans providing benefits to state employees estimated to be about $14,000 (The state would be responsible for 93.9% of any additional costs experienced by the traditional insurance plans or passed on to the state by the managed care plans).

Background Information on Testing: This bill requires each pregnant woman, with the approval of the woman, to be tested for HIV. The bill requires that a blood sample be taken from a woman at the time of

delivery if there is no written evidence that the woman was tested for HIV during her pregnancy. It is estimated that in FY 2002, Medicaid paid for 29,949 total deliveries. Approximately 5,444 of these women were enrolled in the Medicaid RBMC program for which the testing costs would be covered under a capitated rate. OMPP reports that 18,623 of the individuals, received Medicaid services under the PCCM system, which is a modified fee-for-service system. The remaining 5,880 deliveries were paid as routine fee-for-service claims with no patient management payment component. Therefore, Medicaid will be responsible for an estimated 24,503 HIV tests under a fee-for-service payment system. The state share of Medicaid is projected to be about 38%.

In FY 2002, Medicaid paid for a total of 4,839 HIV tests for women who received pregnancy-related services. There is no relationship between the HIV testing done and the birth claims that were processed during the same fiscal year. However, this information does indicate that screening in Indiana may not be done at the rates reported for the country as a whole. One national source estimates that 75% of pregnant women who are receiving prenatal care are offered HIV tests and about 80% of that group accept the test. The HIV testing statistics based on claims paid by the Indiana Medicaid Program indicate that the testing percentage may be lower than 20%. However, it should be noted that there may have been more screening performed on pregnant Medicaid recipients by providers or clinics that did not bill Medicaid. Additionally, OMPP has acknowledged that shadow claims data reported by the managed care organizations (MCOs) is not reliable. The extent of the confidential screening being performed outside the Medicaid Program is unknown.

It is assumed that the average Medicaid cost of the initial HIV test is $14.56, with the state share being $5.54. If all of the fee-for-service claims representing 24,503 women or newborns are tested, and we assume that 3,447 of this group is already being tested, the annual incremental state share of the HIV test would be $116,650. If an individual tests positive on the initial test, the test will have to be administered a second time. It is estimated that 43 babies were born exposed to HIV in 1996 in Indiana. Using the percentage of Medicaid babies to total babies born, it is estimated that as many as 16 Medicaid-eligible pregnant women or newborns would need to be tested a second time. The cost of the second test to the state would be about $89.00 (16 x $5.54). If the test is positive a second time, the Western Blot test is used to determine HIV-positive status. The cost of the Western Blot test is estimated to be $25.07 with the state share being approximately $9.53. The cost to the state to test the 16 estimated HIV-positive pregnant women or newborns is estimated to be $152.00 ($9.53 x 16). The total estimated state share of testing Medicaid-eligible pregnant women or the newborn babies under the fee-for-service claims payment system would be approximately $116,900.

About 18% of the Medicaid-eligible women and newborns are enrolled in the Risk-Based Managed Care program for which the testing costs would be covered under a capitated rate. While there is no short-term impact to the state for the individuals in the RBMC program, increased costs of about $30,200 would likely be factored into higher capitation rates in the future. This analysis assumes that no HIV testing is currently being done on this population (the existing cost is assumed to be included in the fee-for-service group). In practice some portion of the existing test expense may already be included in the existing capitated rates.

Future shifts of PCCM and other fee-for-service patients to risk-based managed care as required in P.L. 291-2001 for the seven largest counties in the state would be expected to consider these costs in the negotiated capitated rates. OMPP reported that 5,880 deliveries were paid under a fee-for-service arrangement in FY 2002. This statistic indicates there was not enough time for Medicaid to assign the woman to a PCCM or managed care organization. Nearly 20% of the total women with deliveries entered the Medicaid program in late term.

Hospital-Based Testing: The bill requires that a blood sample is to be taken from the woman at the time of delivery if there is no written evidence that the woman was tested for HIV during her pregnancy. The Department of Health reports that this provision may result in duplicate testing since the mother's prenatal care chart may not be received by the hospital prior to the delivery for a variety of reasons. The fiscal impact of this provision involves any duplicate testing that would occur as well as any testing of newborns, since this is an existing practice. The extent to which this situation occurs is unknown.

Current law allows for the testing of newborns if a physician caring for the infant believes that it is medically necessary. The bill would require that any HIV testing done on a pregnant woman or an infant within the context of the delivery diagnosis related grouping (DRG) must be paid in an amount equal to the hospital's cost of performing the test. This provision applies to Medicaid as well as private insurance. Under the Medicaid program and other insurance programs, hospitals are paid per admission based on the DRG. These rates are based on average types and intensity of services. Medicaid rebases its DRG payment rate to hospitals every two years. Consequently, new requirements that change the mix or intensity of services to a defined group of patients will not be included in the average calculations that make up the basis of the DRG payment. Additionally, when the rates are rebased, the cost of the HIV test would specifically need to be segregated in order to avoid including it in the new payment rate while this requirement remains in effect.

Potential Savings: Recent medical research has determined that administering the drug zidovudine (ZDV, formerly known as AZT) during pregnancy and childbirth could reduce by two-thirds the chance that an HIV-positive mother would give birth to an infected child. If HIV-positive Medicaid-eligible women are treated during pregnancy, there could be a reduction in the number of Medicaid-eligible babies with HIV. Decreasing the number of exposed and potentially infected infants could offset the expenditures for testing. The State Department of Health reported in CY 2000, 45 pediatric cases of HIV disease or exposure reflected mostly HIV-infected women who gave birth. Of these 45 children born to HIV-infected mothers, 39 of the mothers knew before delivery that they were infected.

The Health Care Financing Administration (HCFA) reported in 1998 that 90% of children and more than 70% of women with AIDS are covered by Medicaid. The average total lifetime charges for the care of children with HIV infection was estimated at $491,963 in the *Pediatric Infectious Disease Journal* (June 1997). This estimate was based on a child's median survival time of 120 months and the cost of both hospital-based and outpatient charges. In Indiana, Medicaid program expenditures for HIV-infected children averaged $13,535 per child in FY 2001 and $9,980 in FY 2002. Information from Riley Hospital indicates that outpatient expenditures for perinatally prevented infants average about $1,350 per child.

Impact on State Employee Health Plans: The initial costs to the state employee health plans from the testing required by this bill is estimated to be about $14,000 per year. These estimates are based on about 900 covered births on the state plan in CY 2000. The state currently pays 93.9% of the premiums for employee group health plans. Employee contributions comprise the remaining 6.1% of the premium. The current state ratio is higher than the CY 2001 average state share of 93.5% due to recent premium increases. This analysis assumes that no HIV testing is currently being done on this population.

Impact on State Department of Health: The bill requires the State Department of Health to develop written materials that explain the treatment options available to an individual who has tested positive for HIV. The written materials are required to be distributed to physicians statewide. The cost of developing and distributing these materials can be absorbed within the existing budget. The bill also requires the Department to include certain information regarding HIV testing of the mother of the child on the birth certificate. (This information is kept within the Department of Health. It is not printed on the public copy of the birth

certificate.) The Department estimates that if the changes are implemented this year, the required changes to the electronic birth certificate could be absorbed within the resources devoted to the revisions currently being programed in the vital statistics database. The bill would also require the Department to develop an HIV test history and assessment form for the medical record of the mother, the infant, and the hospital pediatrician. The bill also requires the Department to maintain a systemwide evaluation of prenatal HIV testing in the state.

Explanation of State Revenues:

Explanation of Local Expenditures: Similar to the state, increased premiums and enrollment fees may result in additional costs to local governments and school corporations purchasing health benefits from insurance companies and HMOs for their employee health benefit plans. However, this may not necessarily imply additional budgetary outlays since employer responses to increased health benefit costs may include: (1) greater employee cost sharing in health benefits; (2) reduction or elimination of health benefits; (3) reduction in the size of the workforce eligible for health benefits; and (4) passing costs onto workers in the form of lower wage increases than would have been granted before.

Explanation of Local Revenues:

State Agencies Affected: All; Family and Social Services Administration; State Department of Health.

Local Agencies Affected: Local Governments and School Corporations; Local Health Departments.

Information Sources: Office of Medicaid Policy and Planning; Martin B. Kleiman, M.D., Director, Pediatric Infectious Disease Clinic, Riley Hospital for Children; Carroll Causeway, Indiana State Medical Association; State Department of Health; Institute of Medicine's report on Prenatal Testing for HIV; National Conference of State Legislatures, HIV/AIDS Facts to Consider: 1999.

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